**Complement Fixation Tests in Thrombo-angiitis Obliterans.**—The pathological study of this condition was published in this journal in October, 1908. It showed that most of the arteries, and sometimes the veins as well, are obliterated over a large extent of their course in the lower extremities. All stages of the occlusive change occur in the various vessels of an extremity or in the same vessel in different parts of its course. The closure is effected by red obturating thrombi; these become organized, vascularized, and canalized. These lesions are not secondary to the gangrene; they may occur without the latter. In short, the condition is initiated by the formation of occlusive thrombi, chiefly in the arteries, but not confined to these, followed by organization or healing, with an attempt at the production of a collateral circulation. This results clinically in pains, ischemia, cyanosis, and trophic disturbances in the affected limb, even extensive gangrene. BUERGER and KALISKI (*Medical Record*, 1910, lxxviii, 665), realizing that this periarteritis might suggest syphilis, have investigated a series of cases with this in view. The authors and Oppenheimer failed to demonstrate Spirochæta pallida in any of the vessels removed from amputated limbs. Nothing definite was ascertained in the histological study to throw light upon the etiology of the process. Clinically, a history of lues in these cases is rarely elicited. Only 2 out of 80 had had a definite syphilitic infection. Twenty-nine cases were examined serologically by complement fixation tests for syphilis. In every one of the 29 the reaction was definitely negative. In only 1 of these could mercurial treatment be considered as influencing the reaction. Buerger and Kaliski conclude that it is fair to assume the disease is probably not of luetic origin.

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**The Auscultatory Method of Determining Blood Pressure.**—In 1905 Kurotkon described the auscultatory method of measuring blood pressure. With the ordinary cuff and manometer, if a stethoscope be placed over the artery below the cuff, avoiding pressure, and the air gradually released, a remarkable cycle will present itself. GOODMAN and HOWELL (*Univ. Penn. Med. Bull.*, 1910, xxiii, 469) have measured the five different phases of this cycle in figures of pressure on the manometer. With a normal pressure, systolic 130 mm. and diastolic 85 mm., the phases are clear-cut and bear a definite relation to the differences between the extremes of pressure. First, is heard a loud, clear-cut, snapping tone (first phase), due to sudden distention of the vessel walls by the inrush of blood. This persists from the point of systolic pressure for 14 mm. Then follows a series of murmurs, during a drop of 20 mm., the second phase, due to whirlpool eddies produced at the point of constriction of the lumen by the cuff. Suddenly they disappear and a tone which resembles the first is heard. This is the third phase, due to a now well-established stream in the vessel. It lasts for 5 mm., and is followed by a dulling of the sound, for 6 mm., a transitional fourth phase. The fifth phase marks the diastolic pressure. At this point all sounds disappear. Goodman and Howell believe this method to be preferred for simplicity and accuracy. Absence of the fifth phase is pathognomonic of aortic insufficiency. They believe variation in sequence relation of the phase, the recognition of tonal arrhythmias, and irregularities in maximal and minimal pressures will prove of much value in the diagnosis of cardiac neuroses.

**Dysentery Carriers.**—MACALISTER (*Brit. Med. Jour.*, 1910, ii, 1506) divides carriers into two great classes. The first class consists of healthy persons, who have never suffered from the disease and show no signs of ill health, but nevertheless harbor and scatter the specific organism. In the instance of bacillary dysentery this class is small and unimportant. The author has never found a single case, but Conradi, Collins, and Mayer have been able to demonstrate such conditions in both children and adults living among those affected with the disease. In the second class are people who have had the disease and are thereafter unable completely to eliminate the infection. As agents in the spread of the disease this group cannot well be overestimated in importance. They consist of two groups, in the first of which convalescence is discovered only by the continuation of agglutination. They do not relapse, but they harbor infection somewhere, and an occasional stool contains mucus. The second group is of relapsing and chronic cases, a constant source of infection. Macalister emphasizes the need of isolation, observation, and care during convalescence as a means of prevention of spread of an epidemic. Unfortunately, these incomplete convalescents form a high proportion of the cases.

**The Parathyroid Glands and Sudden Death.**—As a cause of sudden death in children, not a few cases of status lymphaticus have been recorded. But it often happens that necropsy reveals no adequate cause of death. GROSSER and BETKE (*Münch. med. Woch.*, 1910, lvii, 2077) report 3 cases which would fall in the latter category, had they not carefully dissected and examined the parathyroid glandules histologically. In all their cases no lesion sufficient to cause death was found, aside from the changes in the parathyroids. In 2 cases they found only three glandules —all hemorrhagic. In the remaining case all four glands presented fresh, extensive hemorrhages. Similar lesions were not discovered in other organs. From a study of the literature, they find that more than one parathyroid gland must remain intact to preserve life. They believe, therefore, that the lesions they found in these glands are quite sufficient to explain the death of the patients, and urge the necessity of their careful examination in cases which are obscure. The patients died with spasms.

**Anemia and Hemolytic Icterus of Tuberculous Origin.**—LANDOUZY (*Presse médicale*, 1910, 761) reports the case of a young man, aged thirty-eight years, with pulmonary tuberculosis. The man had a severe grade of anemia—red blood corpuscles, 1,050,000, and hemoglobin, 10 per cent. The spleen was enlarged. The conjunctivæ were subicteric, and the urine highly colored (urobilin). A diminution in the resistance of the red blood corpuscles was demonstrated (0.54 per cent.). As many as 25 per cent. of the red cells showed granules on vital staining, and the nucleated red cells amounted to 35 per cent. The patient's serum contained neither isolysins nor autolysins. After a time, under treatment, the signs of infection regressed, with a similar change in the anemia and icterus. As the pulmonary lesions seemed to become stationary, the fragility of the red blood cells disappeared. This parallelism of the hemolytic syndrome and the infection and the absence of any other cause leads Landouzy to believe the hemolytic jaundice dependent